

REVIEW

Attention deficit hyperactivity disorder: legal and ethical aspects

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Attention deficit–hyperactivity disorder (ADHD) remains a controversial disorder, despite it now being a well validated clinical diagnosis. Ethical and legal issues are important in determining how doctors should behave in offering a diagnosis or treatment that may generate strong and unpredictable reactions from children, their families, or other agencies. A model for routine ethical practice was proposed, based on three sets of assumptions. Firstly, that ethical practice is consistent with the four principles of beneficence, non-maleficence, justice, and respect for autonomy. Secondly, ethical concerns lead to legal processes, whose task is to ensure ethical practice. Thirdly, that we are working in the interests of our patients. Current relevant literature was organised in terms of this model, and recommendations for practice derived from it. Though there is no general ethical problem regarding either the routine diagnosis or treatment of ADHD, ethical difficulties surround some special cases, especially when doctors are working in conjunction with other agencies or coping with non-medical frameworks. Particular care needs to be taken with confidentiality and consent, the limits of which are currently confused. The model worked well with everyday ethical problems, though more difficult cases required careful individual scrutiny.

processes should be interpreted—with respect to doctors and as far as possible—as applications of the ethical principles just mentioned, and should be followed accordingly. Thirdly, we should work to the interests of our patients. This allows the development of a working ethical model to provide useful, reliable guidance, in ordinary clinical practice. Any model for practitioners' use must give the right result in common cases, and should be both clinically and legally reliable in "everyday" dilemmas. While this model does struggle to address some very complex problems, the limits of the model do not invalidate it, as the most difficult ethical and legal issues often require "tailor-made" approaches, rather than an ethical or medico-legal algorithm. So, finding a circumstance that the model cannot address warns practitioners to examine the ethical or legal issues they are grappling with in more detail, and seek additional specialised advice.

THE FOUR PRINCIPLES AND HOW TO APPLY THEM

There is much to be said for defining ethical practice in terms of a few, easily digestible principles. Principles simplify coping with multifarious circumstances by abstracting common components from them, allowing one to generalise ethical practice consistently across many different situations. Beauchamp and Childress⁴ have developed four such principles that have proved useful in medical ethics: respect for autonomy; beneficence; non-maleficence; and justice. Respect for autonomy informs debates over issues of consent, competence, and disclosure of professional information. Respect for autonomy is more than an attitude. To show such respect, we must act in such a way that the autonomy of the patient is enabled, and limits to that autonomy are acknowledged. Beneficence is what we hope to do when we treat someone. It can refer to both actions that do good, or those that prevent harm. Non-maleficence is better known as the maxim "primum non nocere" (first do no harm). What non-maleficence is really about is distinguishing between effects and side effects of treatment. It reminds us that the balance of benefit of intended and unintended effects of an intervention should always be positive. Justice is concerned with how people are treated by each other: in particular, justice embodies the idea that equals should be treated equally, and unequals treated unequally. While there are many definitions of justice, Rawls' explication of it as fairness⁵ carries a close

Attention deficit–hyperactivity disorder (ADHD) is the commonest neuropsychiatric disorder of childhood, its most severe form, hyperkinesia, affecting 1% of UK children.¹ However, case definitions vary,² and while effective treatments exist, their use is repeatedly questioned.³ Considering legal and ethical issues in delivering services to these children can assist practitioners in four ways. It can help them decide whether their current approach conforms to good practice, defend their decisions against inappropriate pressure, identify potential areas of difficulty or uncertainty, and suggest appropriate courses of action. This maximises the chances that practitioners will make those decisions that best assist these children.

I begin with three assumptions. Firstly, ethical medical practice must be consistent with respect to four principles: respect for autonomy, beneficence, non-maleficence, and justice. Secondly, ethical concerns lead to legal processes, whose task is to ensure ethical practice. So, legal

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correspondence to current British health practice and policy.⁶

Knowing the principles does not tell one how to use them. Beauchamp and Childress recommend three interrelated techniques, which they call *specification*, *dialectic*, and *balancing*. Specification describes how the principles are related to norms and practical judgements, leading to guidance towards action. Without this, principles become empty formalism, which allows one to justify any action by appeal to a judicious combination of circumstances. Dialectic involves comparing our “considered judgement” on particular situations with the predictions of ethical theories, seeking to maximise the coherence between them. Balancing refers to the process of assigning different weights to various norms that may conflict with each other, helping one choose an appropriate course of action. In the simplified model I propose here, the role of “ethical theories” and “norms” is taken by our current legal framework and guidance, as well as the four principles, while “practical” and “considered” judgements are, of course, our professional opinions.

APPLYING ETHICS AND THE LAW TO HYPERACTIVE CHILDREN

Consider an ordinary referral for a hyperactive child, who is assessed, diagnosed, and treated. We begin by meeting our legal duty to manage the referral to ensure it is treated optimally.⁷ We seek consent, aware that assessment or treatment without consent normally constitutes the legal offence of battery.⁷ Usually we seek consent from the parents, but try to take the child’s views and wishes into account. Despite concerns about whether this offers children, particularly teenagers, sufficient autonomy, the overwhelming weight of law and guidance is on our side.⁸ We undertake a thorough assessment and treat on its basis, ensuring both assessment and treatment consistent with current professional guidelines,⁹ meeting the legal requirement that our practice should be both reasonable and agreed with our peers.¹⁰ This process clearly involves respect for autonomy in obtaining appropriate consent, beneficence, and non-maleficence in providing appropriate care. Justice is also involved, though less obviously: for example, we consider it just (fair) to be expected to manage the assessment and medical treatment of these cases well, while the legal framework and guidance just outlined tells us what “well” means. Our model tells us that, if we approach ordinary cases of hyperactivity in an ordinary way, we are acting both ethically and legally. There is more to this than reassurance. Despite the controversy surrounding it, the diagnosis of hyperactivity is at least as well established as other medical diagnoses.^{11 12} So, our model permits us to use the diagnosis despite doubt, while philosophical or theoretical objections are not sufficient grounds to refuse to make the diagnosis—any objections must be specified in terms of the model. The model similarly makes clear that we should not be swayed by prejudice in treatment: being “against medication” must be justifiable in terms of the individual patient, against the standards set by the model. In both cases, the alternative is to risk ethical criticism or even legal sanction. Ethical practice is not political correctness.

Given the safety of the treatments available for hyperactivity,¹³ and the significant disability the condition imposes,¹⁴ beneficence and non-maleficence rarely conflict. Respect for autonomy presents few challenges at initial assessment, as the children are usually so young that one may place the overwhelming responsibility for consent on the parents who have brought the child and still respect the child’s autonomy. As the treatment is over several years, the model suggests that the child’s appreciation of the treatment should be reviewed as time passes, to ensure that practitioners appreciate how the balance of autonomy is shifting,

and can respond to it as necessary. “Gillick competence”—that is, to understand the treatment and its benefits sufficiently to give informed consent, which a child must possess in order to give consent independent without parents, is based on an assessment of the child’s competencies, not age.¹⁵ Though a child’s wishes may be overruled until 18, assessment of autonomy is essential to ensure that sufficient weight is given to the child’s views, as in the case of an older child they may not be upset lightly.^{16 17} Only those with parental responsibility can give consent for more than immediate or emergency treatment, though only one parent is needed to consent.¹⁸ People who *cannot* give full consent include teachers at boarding schools, foster-carers, unmarried fathers, or stepfathers who have not been granted parental rights by a court, and social workers unless the child is under a care order—being “accommodated” or under a supervision order will not do. So, practitioners must be careful that the adult with the child is actually able to give consent, if the child (as is usually the case in hyperactivity) is not “Gillick” competent.

Commonly, hyperactivity presents practitioners with ethical conflicts between beneficence/non-maleficence and justice. Teachers may tell practitioners, before diagnosis, that the child will not be allowed back to school unless medicated, or a diagnosis is required before special educational provision is made available. Hyperactive impulsivity can lead to demands for retribution from its victims, either informally or through the courts. Each reader can no doubt think of their own examples. In all of these situations the model directs us to first consider the needs of the child, as the object of our actions. We must then balance the conflicting principles, specified by our professional knowledge and the legal framework, to ensure the best possible outcome for the child. For example, in the case of the school requiring medication before admission, the model would indicate contact with the school to educate them about medication’s uses and limitations, rather than either flat opposition (which would be in breach of educational and medical guidance about joint working) or uncritical agreement (which neglects making proper medical judgement of the needs of the child). Having thus specified and balanced, we hope that a resolution will arise through the dialectic with the school.

AT THE MODEL’S LIMITS

The model struggles to address two areas: confidentiality, and the limits of the child’s or family’s rights of consent.

Confidentiality presents problems because GMC guidance may in some cases be at variance with case law, making balancing ultimately impossible.¹⁹ In general terms disclosure of information without consent may take place if there are concerns about child protection, lawbreaking, or harm to others, and there is also “catch-all” guidance that covers most situations where professionals need to communicate for the good of the child.²⁰ However, doubts about disclosure should encourage practitioners to seek advice from a specialist, for example, a defence organisation.

Setting the limits for children’s consent for treatment, especially mental health treatment, is in chaos. The new, rights based approach to treating children stresses respect for autonomy,⁸ while medical law is paternalistic, with the “inherent jurisdiction” of the court ultimately brooking no refusal.¹⁷ Both juvenile criminal law²¹ and new mental health legislation give primacy to public order concerns. Also, the effect of current mental health legislation on mentally ill children is to *confer* rights that children do not have under common law,²² and this approach is extended under new proposals: competent children aged 16–17 will have a right of refusal for psychiatric treatment against the wishes of their parents, and younger children receiving inpatient psychiatric

treatment on parental consent only will have special safeguards.²³ Children subject to provisions of the Children Act can already refuse psychiatric examination, though not for educational purposes. Ordinary practice usually accepts that parents of hyperactive children have a right to refuse treatment. However, someone acting on behalf of a child must act *rationality* in the child's best interests,²⁴ and some of the legislation mentioned above curtails the parents' rights in this area also. While the decision to overrule a child's views is always difficult, overruling a family is more so, and can lead to heartbreaking results.²⁵ Once the practitioner faces more than grumbling acquiescence, the decision to force treatment on a competent hyperactive child should be taken by practitioners trained in the Mental Health Act, and opposing a family's wishes should be discussed with other agencies, especially Social Services, as a matter to be set before the courts. Though the model may still be helpful in framing the ethical dilemmas involved, it will probably be unable to distinguish between several, mutually incompatible solutions, without additional reflection on the case's specifics. As different solutions will be preferred by different agencies, depending on their remit, practitioners will need to ensure that whatever is decided is consistent with their own professional ethics and practice.

This model has been specified with reference to English law. It is probable that other jurisdictions will have different limits from those identified above. These will need to be identified for each jurisdiction.

CONCLUSIONS

Ethical difficulties are not routine in the management of hyperactivity. In cases which involve several services, civil or criminal law, demands might be placed on practitioners that conflict with good medical practice, so being clear about one's ethical principles and legal guidance is essential. Models for ethical practice can help with more common dilemmas, but practitioners should seek advice in the most difficult cases.

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